

Metropolitan Nashville Public Schools
REQUEST FOR: ASSISTED SELF-ADMINISTRATION OF MEDICATIONS
PRESCRIPTION and NON-PRESCRIPTION MEDICATIONS

Requests for a student to administer his/her own medication during school hours requires that this statement be filed with the school principal. Please respond to every item on this form.* If non-prescription, parent fills out health care provider part.

School _____	School Hours _____	Teacher _____
STUDENT INFORMATION		
Student Name _____ Last First Middle	Date of Birth ____/____/____	
Address _____	Phone _____	
Diagnosis _____		

HEALTH CARE PROVIDER STATEMENT

The health care provider may be a medical doctor (M.D.), physician assistant (P.A.) or a registered nurse practitioner/clinician (RN CS).

To be completed by the health care provider. (If non-prescription medication, parent must fill out.)

Name of Drug / Purpose of Drug _____

Date to Start _____ through _____

Dosage and Times at School _____

Does this medication absolutely need to be administered during school hours?

_____yes _____no If yes, explain _____

Special instructions for Storage and Handling _____

Possible side Effects _____

Health Care Provider Name _____ Phone _____

Address _____

Health Care Provider Signature _____ Date _____
(for prescription medications)

STUDENT AND PARENT STATEMENTS

I take full responsibility for taking my own medication during school hours as prescribed by my health care provider. Medicine bottles will have the proper pharmacy label. If non-prescription medication, it must be in original container.

Student Signature _____ Date _____

I give consent for my child (name) _____ to take his/her own medication during the school day assisted by school personnel as necessary.

I, agree that Metropolitan Nashville Public School System (MNPS), its employees and agents shall not be held liable for any injury resulting from my student's possession and self-administration of the above described medication while on school property or at a school related event. I shall indemnify and hold harmless MNPS, its employees and agents against claims against the possession and self-administration of the above described medication by my student. *My child is competent to self-administer the medication with assistance.* _____yes _____no
(Check one)

Parent/Guardian Signature _____ Date _____

Phone Number (in case of emergency) _____